DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: U T — 0 1 - 030

2. STATE: UTAH

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1902 (a)(13)(A) of the Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2002 $ -0-
b. FFY 2003 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
ATTACHMENT 4.19-A, PAGES 1 through 13

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same, + Section 500

10. SUBJECT OF AMENDMENT:
Inpatient Hospital

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Rod L Betit

13. TYPED NAME:
Rod L. Betit

14. TITLE:
Executive Director
Department of Health

15. DATE SUBMITTED:
December 24, 2001

16. RETURN TO:
Rod L. Betit, Executive Director
Department of Health
Box 143102
Salt Lake City, UT 84114-3102

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
January 2, 2002

18. DATE APPROVED:
3/19/02

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
OCTOBER 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:
Mark Gilbert

21. TYPED NAME:
Mark Gilbert

22. TITLE:
Acting Associate Regional Administrator

23. REMARKS:

POSTMARK: unknown

FORM HCFA-179 (07-92)

Instructions on Back

UTAH STATE PLAN ATTACHMENT 4.19-A

INPATIENT HOSPITAL

01-030
03/19/02
10/01/01

INPATIENT HOSPITAL

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

INPATIENT HOSPITAL
Section 100 Payment Methodology

110 Introduction -- Under a Diagnostic Related Group (DRG) system, hospitals are paid a prospectively determined amount for each qualifying patient discharge. DRG weights are established to recognize the relative amount of resources consumed to treat a particular type of patient. The DRG classification scheme assigns each hospital patient to one of over 500 categories or DRGs based on the patient's diagnosis, age and sex, any surgical procedures performed, complicating conditions, and discharge status. Each DRG is assigned a weighting factor which reflects the quantity and type of hospital services generally needed to treat a patient with that condition. Preset prices are assigned to each DRG. The DRG system allows for outliers for those discharges that have significant variance from the norm. Each DRG has an outlier threshold 2.5 times its base DRG payment.

The DRG method of payment is used for inpatient services for Utah hospitals located in urban communities defined by the Standard Metropolitan Statistical Area (SMSA) and for out-of-state hospitals. In addition, Washington and Cache counties are included in the urban classification. Exceptions to the DRG payment system include (1) the State Psychiatric Hospital, (2) rural hospitals and (3) specialty hospitals, defined in Section 194. Rural hospitals are defined as Utah hospitals located outside of the SMSA. Rural hospitals are paid a negotiated percentage of allowable usual and customary charges.

120 DRGs General -- Except as otherwise provided, the federal DRG methodology definitions are adopted. The Utah Medicaid DRG system does have several unique features. The DRG Utah Weights and arithmetic mean average length of stay (ALOS) are extracted from Medicaid paid claims history files.

The methods for determining Utah Medicaid weights are explained in Section 121. Where insufficient Utah Medicaid history was available, the weights, arithmetic mean ALOS and threshold days were obtained from the U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA), and, in some instances, newborn data from other states' Medicaid data. The HCFA data are published in the Federal Register.

HCFA data are adjusted to be compatible with the weights established with Utah Medicaid paid claims history. In the event HCFA adds new DRG categories, the state will also add those DRGs to be consistent with the certified HCFA DRG grouper tape. The methods used to establish the payment rates and outliers for non-psychiatric DRGs are discussed in Section 121.

The base Medicaid dollar multiplier factor is based on the FY 2000 expenditure history. The dollar multiplier factor is adjusted each year based on the negotiation of a factor for anticipated economic trends and conditions. By signing a provider contract, the hospital agrees to the

established payment rate. Furthermore, when economic conditions change during the year, the state may negotiate to change the terms of the contract including the payment rate with each hospital. Each hospital agrees to the DRG payment under a contractual agreement.

121 DRG Weights and Outliers -- The DRG weights are intended to reflect relative resource consumption. To establish DRG weights, data used were extracted from the Utah paid claims history files for a two-year period. Where the history did not contain a sufficient number of claims to adequately address the variance in charges and patient lengths of stay, HCFA weights, and ALOS were adjusted and used.

The Utah DRG weights were calculated from paid claims history data when there were more than 15 cases. The data base includes FY 1998 and FY 1999 paid claims history. Outliers were excluded in calculating the ALOS. Also, excluded were claims from rural hospitals. The geometric mean charge is calculated for each DRG. A statewide geometric mean charge for all cases is also calculated. The relative weight of each DRG is a function of the relationship between the geometric mean charge for each DRG and the geometric mean charge for all applicable DRGs. To determine the relative weight, the geometric mean charge for each DRG is divided by the statewide geometric mean charge per discharge.

The outlier payment threshold limit is 2.5 times the base DRG payment. Additional payments are paid for charges in excess of the threshold at the rate of 80 percent, adjusted by a case mix and hospital charge structure differential. A case mix index is calculated from the sum of Medicaid weights (excluding outliers) divided by hospital cases for each hospital. The case mix index is normalized. The normalized case mix index is adjusted for the average charge per case (hospital CMI adjusted charge per case), by hospital. The final adjustment factor is then calculated by dividing the hospital CMI adjusted charge per case by the statewide CMI adjusted charge per case.

There is a special calculation for DRGs 433 through 437 involving alcohol and drugs. Because the Medicaid scope of service is limited to detoxification, the payment rate for these DRGs is based on an average length of stay of three days.

122 Dollar Multiplier – There is a single dollar multiplier for all DRGs based on budget dollars available.

123 Effective Dates for Rates -- Payment rates will be effective based on "date of discharge." When a patient is transferred from another hospital, as opposed to discharged, the payment will be calculated using the rate in effect at the time of discharge.

130 Property and Education -- The Medicaid DRG payment rates are all inclusive. There are no designated pass-through costs or other add-on factors for costs such as capital, education or other expenditures. However, these factors are reflected in the hospital charge structure used to calculate the DRG payment.

140 Transfer Patients -- Except as otherwise specified in the State Plan, the federal Medicare methodology will be followed for transfer patients. The hospital which transfers the patient will be paid the DRG per diem fee for each day of care. The per diem is determined by calculating the DRG payment, dividing by the ALOS, and adding one day. Except as provided in the State Medicaid Plan, payment to the transferring hospital may not exceed the full prospective DRG payment rate. In cases of distinct rehabilitation units and hospitals excluded from the DRG prospective payment system, the transfers will be considered discharges and the full DRG payment, including outliers, will be paid. To be eligible for Medicaid payments, the exempt distinct rehabilitation unit must be part of an acute hospital. When a person is appropriately admitted and cared for in an acute hospital and is appropriately transferred to another hospital for extended specialized service and later transferred back to the first hospital, the first hospital is paid the full DRG for the combined stays while the other hospital is paid a per diem under the transfer payment policy. Such per diem payments are not restricted by the DRG payment limitation. Transfers involving hospitals excluded from DRGs will also be paid based on their respective payment methodology.

145 Split Eligibility -- When a Medicaid patient is eligible for only part of the hospital stay, the Medicaid payment will be calculated by the following formula:

> Claim Payment = Medicaid Eligible Days divided by Total Hospital Days x Full Medicaid Payment

The split eligible payment constitutes payment in full for all services rendered on those days on which the patient was eligible for Medicaid and must be accepted as such by the provider hospital. The hospital may not bill the patient for any services rendered on those days. In contrast, the hospital can bill the patient full charges for services rendered during those days that the patient is not eligible for Medicaid. When both third-party payments and split eligibility are involved, the third-party payment will first be applied to the period prior to eligibility. Any remaining TPL will be used to reduce the Medicaid payment.

160 Services Covered by DRG Payments -- Medicaid adopts the general provision of the bundling concepts used by Medicare. Physicians, including resident physicians and nurse anesthetists may bill separately under their own provider numbers. Such billings are in addition to the DRG payment. All other inpatient hospital services, as defined by Medicare, are covered by the DRG system. DRGs are paid for inpatient hospital admissions when a baby is delivered even though the mother or baby is discharged in less than 20 hours.

161 Donor Organs -- Medicaid adopts the general Medicare definitions to determine payment for approved donor organs. Medicare regulations and guidelines are used to establish payment amounts for donated organs.

162 Shaken Baby Syndrome Project – In accordance with a national initiative to educate parents to the dangers of shaken baby syndrome, Utah will participate in an educational effort

provided through hospitals. Payment for this educational effort is calculated at $6.00 per delivery in the state. Utah Medicaid will reimburse each DRG hospital $6.00 for all identified Medicaid deliveries (including Medicaid HMO deliveries). Payment will be made to each DRG hospital on a quarterly or annual basis based upon claims data. Rural hospitals receive payment for this project as a percentage of their charges.

165 DRG Determinations -- The Medicare DRG "grouper" software will be used for Medicaid. When changes are made, Utah Medicaid will adopt the changes within 31 days of the Medicare implementation date.

180 Utilization Review and Control of Inpatient Hospital Services -- Payment may be denied or withheld for inpatient hospital services which do not meet Medicaid regulations or criteria for medical necessity and appropriateness. Medicare regulations and guidelines apply when additional clarification or explanation is required. In the event payment is made and the services are subsequently deemed inappropriate or unnecessary, the payment(s) can be recovered through offsets to future payments. Payment may be denied or withheld in the following circumstances:

1. The inpatient care provided in an acute care facility is not medically necessary based on InterQual Criteria for inpatient admission.

2. The claim is based on an incorrect principal diagnosis.

3. The services or procedures requiring prior authorization have been provided without obtaining the appropriate prior authorization.

4. The patient is transferred when there is no medical justification. In the case of inappropriate transfers, the discharging hospital receives the full DRG and the transferring hospital is denied payment.

5. The patient has been readmitted within 30 days of discharge for the same or similar diagnosis. Except for cases related to pregnancy, neonatal jaundice, or chemotherapy, all re-admissions within 30 days of a previous discharge will be reviewed to ensure that Medicaid criteria have been met for: 1) severity of illness, 2) intensity of service, 3) appropriate discharge planning, and 4) financial impact to the State. Outlier days will be paid where appropriate. In addition, all claims are subject to post payment review.

Determinations of medical necessity and appropriateness will be made in accordance with, but not limited to, the following criteria and protocols:

1. The Diagnostic Related Group (DRG) system that was established to recognize the relative amount of resources consumed to treat a specific type of patient. The Utah

DRG weight, average length of stay (ALOS), and outlier threshold days are extracted from Utah Medicaid paid claims history files, where available, or from the U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA).

2. The comprehensive, clinically-based, patient-focused medical review criteria and system developed by InterQual, Inc.

3. The appropriate, Utah-specific Administrative Rules or criteria developed through the Utilization Review Committee for programs and services not otherwise addressed.

4. The determination, where deemed necessary, of the Utilization Review Committee. The Committee must include at least two physicians and two registered nurses. The Committee will review and make recommendation on complicated or questionable individual cases.

190 Exempt Hospitals -- Two categories of hospitals are exempt from DRGs:

The State Hospital will continue to be reimbursed per diem cost for each operating unit. The per diem is calculated using Medicare regulations to definite allowable costs. In applying cost reimbursement principles, the Utah State Hospital is required to capitalize only those assets costing more than $5,000.00 A separate per diem is calculated for each operating unit. Therapeutic leave days are included in the total count of Medicaid days, unless the patient was discharged. However, if a patient is admitted as an inpatient to a second hospital, the patient is deemed to be discharged from the State hospital and the days are not counted. The day count used in the Medicaid cost settlement must be consistently applied for all admissions for all classes and/or groups of patients. Because of their unique patient population, the Utah State Hospital is not part of the DRG system. Medicaid does not use the Medicare methodology to pay an average cost per discharge.

TEFRA limits do not apply because of long lengths of stay experienced by many of the patients.

Rural hospitals located in rural areas of the state are exempt from DRG. Medicare definition of "rural hospital" is adopted by Medicaid. Rural hospitals are paid 93 percent of charges.

194 Specialty Out-Of-State Hospitals -- These hospitals provide inpatient services that are not available in the State of Utah. To qualify for this special payment provision, prior authorization must be obtained from the Utah State Department of Health, Division of Health Care Financing. The payment amount will be established by direct negotiations for each approved patient. The DRG method may or may not be used depending on the negotiated payment. Typically, the Medicaid rate in the State where the hospital is located is paid.